FOR OHF USE

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0027870

Facility Name: St Agnes HC and Rehab Center

Address: 60 East 18th Street (Number) Chicago (City) 60616 (Zip Code)

County: Cook

Telephone Number: (312) 787-9400 **Fax #** (312) 787-9590

IDPA ID Number: 363192742001

Date of Initial License for Current Owners: 07/26/83

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/03 to 12/31/03 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) Jeffrey K. Singer, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Agnes HC and Rehab Center # 0027870 Report Period Beginning: 01/01/03 Ending: 12/31/03

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	171	Skilled (SNF)	171	62,415	1
2		Skilled Pediatric (SNF/PED)			2
3	26	Intermediate (ICF)	26	9,490	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	197	TOTALS	197	71,905	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	52,378	2,131	6,545	61,054	8
9	SNF/PED					9
10	ICF	3,697	308		4,005	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	56,075	2,439	6,545	65,059	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.48%

D. How many bed-hold days during this year were paid by Public Aid?
866 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [x]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [x]

I. On what date did you start providing long term care at this location?
Date started 1/1/1983

J. Was the facility purchased or leased after January 1, 1978?
YES [x] Date 1/1/1983 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 26 and days of care provided 6,545

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 12/31/03 Fiscal Year: 12/31/03

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Agnes HC and Rehab Center # 0027870 Report Period Beginning: 01/01/03 Ending: 12/31/03

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary		26,203	403,279	429,482		429,482		429,482			1
2	Food Purchase		480,006		480,006	(54,108)	425,898	(179)	425,719			2
3	Housekeeping	20,795	51,651	479,605	552,051		552,051		552,051			3
4	Laundry		55,305		55,305		55,305		55,305			4
5	Heat and Other Utilities			210,502	210,502		210,502	1,838	212,340			5
6	Maintenance	34,618		277,690	312,308		312,308	(10,403)	301,905			6
7	Other (specify):*											7
8	**TOTAL General Services**	55,413	613,165	1,371,076	2,039,654	(54,108)	1,985,546	(8,744)	1,976,802			8
	B. Health Care and Programs											
9	Medical Director			1,000	1,000		1,000		1,000			9
10	Nursing and Medical Records	1,287,164	77,567	1,785,566	3,150,297		3,150,297		3,150,297			10
10a	Therapy	17,601		19,316	36,917		36,917		36,917			10a
11	Activities	126,201	13,514	2,256	141,971		141,971		141,971			11
12	Social Services	102,227		31,516	133,743		133,743		133,743			12
13	Nurse Aide Training			1,600	1,600		1,600		1,600			13
14	Program Transportation			300	300		300		300			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,533,193	91,081	1,841,554	3,465,828		3,465,828		3,465,828			16
	C. General Administration											
17	Administrative			660,000	660,000		660,000	(524,819)	135,181			17
18	Directors Fees											18
19	Professional Services			31,146	31,146		31,146	5,930	37,076			19
20	Dues, Fees, Subscriptions & Promotions			41,356	41,356		41,356	(2,122)	39,234			20
21	Clerical & General Office Expenses	45,930	76,651	148,558	271,139		271,139	89,517	360,656			21
22	Employee Benefits & Payroll Taxes			202,232	202,232	54,108	256,340		256,340			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,774	1,774		1,774	152	1,926			24
25	Other Admin. Staff Transportation							4,405	4,405			25
26	Insurance-Prop.Liab.Malpractice			224,220	224,220		224,220	5,629	229,849			26
27	Other (specify):*							41,222	41,222			27
28	**TOTAL General Administration**	45,930	76,651	1,309,286	1,431,867	54,108	1,485,975	(380,086)	1,105,889			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,634,536	780,897	4,521,916	6,937,349		6,937,349	(388,830)	6,548,519			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number St Agnes HC and Rehab Center #0027870 Report Period Beginning: 01/01/03 Ending: 12/31/03

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			75,691	75,691		75,691	96,762	172,453			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			3,733	3,733		3,733	297,176	300,909			32
33	Real Estate Taxes			237,755	237,755		237,755	3,648	241,403			33
34	Rent-Facility & Grounds			273,874	273,874		273,874	(273,874)				34
35	Rent-Equipment & Vehicles			8,982	8,982		8,982		8,982			35
36	Other (specify):*											36
37	**TOTAL Ownership**			600,035	600,035		600,035	123,712	723,747			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	176,228	577,851	155,398	909,477		909,477		909,477			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			10,405	10,405		10,405	(330)	10,075			41
42	Provider Participation Fee			107,857	107,857		107,857		107,857			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**	176,228	577,851	273,660	1,027,739		1,027,739	(330)	1,027,409			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,810,764	1,358,748	5,395,611	8,565,123		8,565,123	(265,448)	8,299,675			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Agnes HC and Rehab Center # 0027870 Report Period Beginning: 01/01/03 Ending: 12/31/03

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	84,325	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(179)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(555)	21		18
19	Entertainment				19
20	Contributions	(1,505)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(2,593)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(1,078)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(71,324)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 7,091		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(272,539)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (272,539)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (265,448)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

St Agnes HC and Rehab Center

IDF 0027870

Report Period Beginning: 01/01/03

Ending: 12/31/03

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Coke Machine	$ (330)	41	1
2	Miscellaneous Expense	(160)	21	2
3	Capitalized R&M	(20,815)	06	3
4	Bldg Company - Professional Fees	(1,815)	19	4
5	Appraisal Fee	(2,500)	19	5
6	Bank Charges	(45,654)	21	6
7	Annual Report Fee	(50)	20	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
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16				16
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93				93
94				94
95				95
96				96
97				97
98				98
99				99
100				100
101	Total	(71,324)		101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number St Agnes HC and Rehab Center # 0027870 Report Period Beginning: 01/01/03 Ending: 12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary													1
2	Food Purchase	(179)											(179)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities			1,838									1,838	5
6	Maintenance	(20,815)		10,412									(10,403)	6
7	Other (specify):*													7
8	**TOTAL General Services**	(20,994)		12,250									(8,744)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records													10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**													16
	C. General Administration													
17	Administrative			(637,007)	56,500	55,688							(524,819)	17
18	Directors Fees													18
19	Professional Services	(4,315)	1,815	8,430									5,930	19
20	Fees, Subscriptions & Promotions	(4,148)		2,026									(2,122)	20
21	Clerical & General Office Expenses	(47,447)		136,964									89,517	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			152									152	24
25	Other Admin. Staff Transportation			4,405									4,405	25
26	Insurance-Prop.Liab.Malpractice			5,629									5,629	26
27	Other (specify):*			28,093	8,556	4,573							41,222	27
28	**TOTAL General Administration**	(55,910)	1,815	(451,308)	65,056	60,261							(380,086)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(76,904)	1,815	(439,058)	65,056	60,261							(388,830)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **St Agnes HC and Rehab Center** **#** **0027870** **Report Period Beginning:** **01/01/03** **Ending:** **12/31/03**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	**84,325**	**7,648**	**4,789**									**96,762**	30
31	Amortization of Pre-Op. & Org.													31
32	Interest		**264,411**	**32,765**									**297,176**	32
33	Real Estate Taxes			**3,648**									**3,648**	33
34	Rent-Facility & Grounds		**(273,874)**										**(273,874)**	34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*													36
37	**TOTAL Ownership**	**84,325**	**(1,815)**	**41,202**									**123,712**	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops	**(330)**											**(330)**	41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	**TOTAL Special Cost Centers**	**(330)**											**(330)**	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	**7,091**		**(397,856)**	**65,056**	**60,261**							**(265,448)**	45

Facility Name & ID Number St Agnes HC and Rehab Center # 0027870 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Peter O'Brien	60.00%	See Attached		See Attached		
Daniel O'Brien	20.00%					
Mary O'Brien	20.00%					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	$ 273,874	1721 Corp	100.00%	$	$ (273,874)	1
2	V	32	Interest Expense		1721 Corp	100.00%	264,411	264,411	2
3	V	30	Depreciation		1721 Corp	100.00%	7,648	7,648	3
4	V	19	Professional Fees		1721 Corp	100.00%	1,815	1,815	4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 273,874			$ 273,874	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Agnes HC and Rehab Center # 0027870 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	MADO MGMT. LP	100.00%	$ 1,838	$ 1,838	15
16	V	6	REPAIRS AND MAINT.				10,412	10,412	16
17	V	17	ADMINISTRATIVE				22,993	22,993	17
18	V	19	PROFESSIONAL FEES				8,430	8,430	18
19	V	20	DUES AND SUBSCRIPTIONS				2,026	2,026	19
20	V	21	CLERICAL AND GENERAL				136,964	136,964	20
21	V	24	SEMINARS				152	152	21
22	V	25	AUTO EXPENSE				4,405	4,405	22
23	V	26	PROPERTY INSURANCE				5,629	5,629	23
24	V	27	GEN. ADMIN. - EMP. BEN.				28,093	28,093	24
25	V	30	DEPRECIATION				4,789	4,789	25
26	V	32	INTEREST				32,765	32,765	26
27	V	33	REAL ESTATE TAXES				3,648	3,648	27
28	V								28
29	V	17	MANAGEMENT FEES	660,000				(660,000)	29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 660,000			$ 262,144	$ * (397,856)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Agnes HC and Rehab Center # 0027870 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V		17	SALARY-D. O'BRIEN	$	MADO MGMT. LP	100.00%	$ 12,500	$ 12,500	15
16	V		27	EMP. BEN.-D. O'BRIEN				4,389	4,389	16
17	V									17
18	V		17	SALARY-P. O'BRIEN				40,000	40,000	18
19	V		27	EMP. BEN.-P. O'BRIEN				3,331	3,331	19
20	V									20
21	V		17	SALARY-C. STUMPF				4,000	4,000	21
22	V		27	EMP. BEN.-C. STUMPF				836	836	22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$ 65,056	$ * 65,056	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Agnes HC and Rehab Center # 0027870 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	MADO MGMT. LP	100.00%	$	$	15
16	V	6	REPAIRS AND MAINTENANCE						16
17	V	10	NURSING SALARY						17
18	V	15	HEALTH CARE - EMP. BEN.						18
19	V	17	ADMINISTRATIVE SALARY				55,688	55,688	19
20	V	21	CLERICAL SALARY						20
21	V	27	GEN. ADMIN. - EMP. BEN.				4,573	4,573	21
22	V	30	DEPRECIATION-WAREHOUSE						22
23	V	33	REAL ESTATE TAXES						23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 60,261	$ * 60,261	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Agnes HC and Rehab Center # 0027870 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	$ 392,850	Windy City Nursing	100.00%	$ 392,850	$	15
16	V	3	Housekeeping	479,605	Windy City Nursing	100.00%	479,605		16
17	V	6	Maintenance	185,045	Windy City Nursing	100.00%	185,045		17
18	V	10	Nursing	1,781,438	Windy City Nursing	100.00%	1,781,438		18
19	V	12	Social Services	27,528	Windy City Nursing	100.00%	27,528		19
20	V	21	Office	128,105	Windy City Nursing	100.00%	128,105		20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 2,994,571			$ 2,994,571	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Agnes HC and Rehab Center # 0027870 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V		10	Nursing Supplies	$ 71,252	St. Agnes Medical	100.00%	$ 71,252	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$ 71,252			$ 71,252	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Agnes HC and Rehab Center # 0027870 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Agnes HC and Rehab Center # 0027870 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Agnes HC and Rehab Center # 0027870 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Agnes HC and Rehab Center # 0027870 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Agnes HC and Rehab Center # 0027870 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Daniel O'Brien	Owner	Administrative	20.00%	See Attached	6.00	15.00%	Allocated	$ 12,500	17-7	1
2	Peter O'Brien	Owner	Administrative	60.00%	See Attached	6.00	10.00%	Allocated	40,000	17-7	2
3	Charles Stumpf	Relative	Administrative	None	See Attached	8.00	18.00%	Allocated	4,000	17-7	3
4	Kathleen Stumpf	Relative	Clerical	None	See Attached	5.00	11.00%	None			4
5	James West	Relative	Clerical	None	See Attached	10.70	27.00%	Allocated	9,355	21-7	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 65,855		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Agnes HC and Rehab Center # 0027870 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [x]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Agnes HC and Rehab Center # 0027870 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: MADO MGMT. LP
Street Address: 1541 N. WELLS ST.
City / State / Zip Code: CHICAGO, IL. 60610
Phone Number: (312) 787-9400
Fax Number: (312) 787-9434

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	242,636	5	$ 6,856	$	65,059	$ 1,838	1
2	6	REPAIRS AND MAINT.	PATIENT DAYS	242,636	5	38,831		65,059	10,412	2
3	17	ADMINISTRATIVE	PATIENT DAYS	242,636	5	85,750	85,750	65,059	22,993	3
4	19	PROFESSIONAL FEES	PATIENT DAYS	242,636	5	31,439		65,059	8,430	4
5	20	DUES AND SUBSCRIPTIONS	PATIENT DAYS	242,636	5	7,556		65,059	2,026	5
6	21	CLERICAL AND GENERAL	PATIENT DAYS	242,636	5	510,803	433,722	65,059	136,964	6
7	24	SEMINARS	PATIENT DAYS	242,636	5	567		65,059	152	7
8	25	AUTO EXPENSE	PATIENT DAYS	242,636	5	16,428		65,059	4,405	8
9	26	PROPERTY INSURANCE	PATIENT DAYS	242,636	5	20,994		65,059	5,629	9
10	27	GEN. ADMIN. - EMP. BEN.	PATIENT DAYS	242,636	5	104,774		65,059	28,093	10
11	30	DEPRECIATION	PATIENT DAYS	242,636	5	17,861		65,059	4,789	11
12	32	INTEREST	PATIENT DAYS	242,636	5	122,195		65,059	32,765	12
13	33	REAL ESTATE TAXES	PATIENT DAYS	242,636	5	13,605		65,059	3,648	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 977,659	$ 519,472		$ 262,144	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Agnes HC and Rehab Center # 0027870 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: MADO MGMT. LP
Street Address: 1541 N. WELLS ST.
City / State / Zip Code: CHICAGO, IL. 60610
Phone Number: (312) 787-9400
Fax Number: (312) 787-9434

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	SALARY-D. O'BRIEN	AVG. HOURS WORKED	24	5	50,000	50,000	6	12,500	1
2	27	EMP. BEN.-D. O'BRIEN	AVG. HOURS WORKED	24	5	17,557		6	4,389	2
3										3
4	17	SALARY-P. O'BRIEN	AVG. HOURS WORKED	45	5	300,000	300,000	6	40,000	4
5	27	EMP. BEN.-P. O'BRIEN	AVG. HOURS WORKED	45	5	24,985		6	3,331	5
6										6
7	17	SALARY-C. STUMPF	AVG. HOURS WORKED	45	5	22,500	22,500	8	4,000	7
8	27	EMP. BEN.-C. STUMPF	AVG. HOURS WORKED	45	5	4,705		8	836	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 419,747	$ 372,500		$ 65,056	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Agnes HC and Rehab Center # 0027870 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: MADO MGMT. LP
Street Address: 1541 N. WELLS ST.
City / State / Zip Code: CHICAGO, IL. 60610
Phone Number: (312) 787-9400
Fax Number: (312) 787-9434

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	DIRECT ALLOCATION		1	1,584				1
2	6	REPAIRS AND MAINTENANCE	DIRECT ALLOCATION		1					2
3	10	NURSING SALARY	DIRECT ALLOCATION		2	33,696	33,696			3
4	15	HEALTH CARE - EMP. BEN.	DIRECT ALLOCATION		2	3,426				4
5	17	ADMINISTRATIVE SALARY	DIRECT ALLOCATION		5	290,832	290,832		55,688	5
6	21	CLERICAL SALARY	DIRECT ALLOCATION		2	69,017	69,017			6
7	27	GEN. ADMIN. - EMP. BEN.	DIRECT ALLOCATION		5	62,200			4,573	7
8	30	DEPRECIATION-WAREHOUSE	AVG. HOURS WORKED		1	216				8
9	33	REAL ESTATE TAXES	AVG. HOURS WORKED		1	3,735				9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 464,706	$ 393,545		$ 60,261	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Agnes HC and Rehab Center # 0027870 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Windy City Nursing
Street Address: 1541 N. Wells
City / State / Zip Code: Chicago, IL 60601
Phone Number: (312) 787-6400
Fax Number: (312) 787-9434

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Direct Allocation			$	$		$ 392,850	1
2	3	Housekeeping	Direct Allocation						479,605	2
3	6	Maintenance	Direct Allocation						185,045	3
4	10	Nursing	Direct Allocation						1,781,438	4
5	12	Social Services	Direct Allocation						27,528	5
6	21	Office	Direct Allocation						128,105	6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 2,994,571	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Agnes HC and Rehab Center # 0027870 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: St. Agnes Medical Equipment
Street Address: 1541 N. Wells
City / State / Zip Code: Chicago, IL 60601
Phone Number: (312) 787-9400
Fax Number: (312) 787-9434

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	Nursing Supplies	Direct Allocation			$	$		$ 71,252	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 71,252	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Agnes HC and Rehab Center # 0027870 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Agnes HC and Rehab Center # 0027870 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Agnes HC and Rehab Center # 0027870 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Agnes HC and Rehab Center # 0027870 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Agnes HC and Rehab Center # 0027870 Report Period Beginning: 01/01/03 Ending: 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	Insurance Financing										3,733	6
7												7
8	See Supplemental Schedule							2,910,339			264,411	8
9	TOTAL Facility Related						$	$ 2,910,339			$ 268,144	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13	See Supplemental Schedule										32,765	13
14	TOTAL Non-Facility Related						$	$			$ 32,765	14
15	TOTALS (line 9+line14)						$	$ 2,910,339			$ 300,909	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number St Agnes HC and Rehab Center # 0027870 Report Period Beginning: 01/01/03 Ending: 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8	St. Agnes Medical Equip	X		Working Capital			$	$ 35,000			$	8
9	Building Company	X		Working Capital				2,875,339			264,411	9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital							2,910,339			264,411	14
	B. Non-Facility Related*											
15	Allocated MADO Mgmt						$	$			$ 32,765	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related										32,765	20

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number St Agnes HC and Rehab Center # 0027870 Report Period Beginning: 01/01/03 Ending: 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2002 report.	$	251,079	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	243,400	2
3. Under or (over) accrual (line 2 minus line 1).	$	(7,679)	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)	$	249,081	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	241,402	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1998	245,703	8
	1999	240,677	9
	2000	231,084	10
	2001	237,094	11
	2002	239,752	12

Accrual = 239,752 X 1.04 = 249,081 (ROUNDED)

MADO Allocation = 3,648

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME St Agnes HC and Rehab Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0027870

CONTACT PERSON REGARDING THIS REPORT : Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	17-22-301-014-0000	Long Term Care Property	$ 10,390.03	$ 10,390.03
2.	17-22-301-015-0000	Long Term Care Property	$ 29,908.47	$ 29,908.47
3.	17-22-301-016-0000	Long Term Care Property	$ 126,338.54	$ 126,338.54
4.	17-22-301-017-0000	Long Term Care Property	$ 60,799.19	$ 60,799.19
5.	17-22-301-050-0000	Long Term Care Property	$ 12,315.81	$ 12,315.81
6.	17-04-204-012-0000	Home Office Allocation	$ 13,605.00	$ 3,648.00
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 253,357.04	$ 243,400.04

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? x YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME St Agnes HC and Rehab Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0027870

CONTACT PERSON REGARDING THIS REPORT : Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number St Agnes HC and Rehab Center # 0027870 Report Period Beginning: 01/01/03 Ending: 12/31/03

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 68,975 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 3

C. Does the Operating Entity? [ ] (a) Own the Facility [x] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [x] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	31,879		$ 75,250	1
2					2
3	TOTALS	31,879		$ 75,250	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Agnes HC and Rehab Center # 0027870 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1983	1,400,995		20	29,229	29,229	1,333,294	9
10	Various			1984	132,601		20	6,630	6,630	132,026	10
11	Various			1986	21,150		20	-		21,150	11
12	Various			1987	10,000		20	500	(500)	9,836	12
13	Various			1989	72,045		20	3,603	3,603	44,301	13
14	Various			1990	150,700		20	7,329	7,329	84,940	14
15	Various			1991	37,665		20	1,883	1,883	20,620	15
16	Various			1992	45,688		20	2,285	2,285	18,320	16
17	Various			1993	56,127		20	2,806	2,806	24,593	17
18	Various			1994	133,605		20	6,681	6,681	56,511	18
19	Various			1995	110,000		20	7,790	7,790	65,839	19
20	Various			1996	192,259		20	9,616	9,616	71,344	20
21	Various			1997	244,818		20	12,243	12,243	79,654	21
22	Various			1998	312,914		20	15,649	15,649	86,905	22
23	Various			1999	387,533		20	19,381	19,381	77,522	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number St Agnes HC and Rehab Center # 0027870 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12-BLDG & 12A-BLDG)		424,750					424,750	67
68	Related Party Allocations (Pages 12-REP & 12A-REP)		84,729	2,864		3,133	269	25,367	68
69	Financial Statement Depreciation			56,139			(56,139)		69
70	TOTAL (lines 4 thru 69)		$ 3,817,579	$ 59,003		$ 128,758	$ 68,755	$ 2,576,972	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number St Agnes HC and Rehab Center # 0027870 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 3,817,579	$ 59,003		$ 128,758	$ 69,755	$ 2,576,972	1
2	Fire Equipment	2000	17,038		20	852	852	2,627	2
3	Wiring	2000	1,600		20	80	80	247	3
4	Sprinkler Project	2000	3,381		20	169	169	521	4
5	Fixtures	2000	767		20	38	38	118	5
6	Fence	2000	550		20	28	28	85	6
7	Fire Proofing	2000	1,010		20	51	51	156	7
8	Fire Detection Systm	2000	625		20	31	31	97	8
9	Master Box	2000	1,090		20	55	55	169	9
10	Roof Repairs	2000	22,260		20	1,113	1,113	3,432	10
11	Sprinkler Repairs	2000	1,107		20	55	55	171	11
12	Concrete Work	2000	2,450		20	123	123	378	12
13	Blinds	2000	2,474		20	124	124	381	13
14	Test Header	2000	5,656		20	283	283	873	14
15	Microprocessor	2000	3,890		20	195	195	600	15
16	Block Sealer	2000	5,736		20	287	287	885	16
17	Shutters	2001	2,656		20	133	133	366	17
18	Shutters	2001	1,180		20	59	59	157	18
19	Handrails	2001	1,665		20	83	83	229	19
20	Elevator	2001	27,500		20	1,375	1,375	4,010	20
21	Verticle Blinds	2001	2,150		20	108	108	323	21
22	Tile	2001	2,450		20	123	123	358	22
23	Steam Table Covers	2001	1,850		20	93	93	263	23
24	Heat Exchanger	2001	1,740		20	87	87	247	24
25	Electrical	2001	1,150		20	58	58	159	25
26	Door System	2001	5,485		20	274	274	732	26
27	Verticle Blinds	2001	2,216		20	111	111	296	27
28	Door System	2001	1,500		20	75	75	206	28
29	Fire & Security Syst	2001	5,165		20	258	258	668	29
30	Fence & Drive Gate	2001	2,450		20	123	123	307	30
31	Verticle Blinds	2001	3,281		20	164	164	396	31
32	Drive Unit	2001	3,700		20	185	185	432	32
33	Verticle Blinds	2001	1,875		20	94	94	212	33
34	TOTAL (lines 1 thru 33)		$ 3,955,226	$ 59,003		$ 135,645	$ 76,642	$ 2,597,073	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number St Agnes HC and Rehab Center # 0027870 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 3,955,226	$ 59,003		$ 135,645	$ 76,642	$ 2,597,073	1
2	Electrical	2001	16,320		20	816	816	1,836	2
3	Handrail	2001	650		20	33	33	98	3
4	Hot Water Unit	2001	550		20	28	28	83	4
5	Burner Repairs	2001	710		20	36	36	104	5
6	Power Venter	2001	795		20	40	40	117	6
7	Ceiling Tiles	2001	3,026		20	151	151	454	7
8	Ceiling Fan	2001	696		20	35	35	99	8
9	Concrete Work	2001	875		20	44	44	117	9
10	Ceiling Tiles	2001	666		20	33	33	95	10
11	Light Fixtures	2001	540		20	27	27	77	11
12	Fence	2001	725		20	36	36	94	12
13	Ac Repairs	2001	530		20	27	27	67	13
14	Roof Repairs	2001	1,450		20	73	73	182	14
15	Heater Booster	2001	591		20	30	30	72	15
16	Roof Repairs	2001	1,400		20	70	70	169	16
17	Electrical Repairs	2001	962		20	48	48	108	17
18	Pipe Work	2001	1,375		20	69	69	161	18
19	Light Fixtures	2001	1,086		20	54	54	123	19
20	Pump	2001	551		20	28	28	62	20
21	Ceiling Tiles	2001	1,160		20	58	58	131	21
22	Motor	2001	602		20	30	30	65	22
23	Painting	2001	676		20	34	34	74	23
24	Ceiling Tiles	2001	1,102		20	55	55	119	24
25	Bathroom Remodel	2001	2,737		20	137	137	331	25
26	Vertical Blinds	2002	4,176		20	418	418	835	26
27	Elevator	2002	27,500		20	1,375	1,375	2,521	27
28	Air Conditioner	2002	2,704		20	225	225	376	28
29	Smoke Detector Alarm Systems	2002	796		20	114	114	227	29
30	Water Gallon Extinguisher Repair	2002	623		20	89	89	178	30
31	Repair Fire Alarm Systems	2002	646		20	92	92	185	31
32	Door Closer Repairs	2002	611		20	61	61	122	32
33	Fire Alarm Wiring Repairs	2002	600		20	86	86	164	33
34	TOTAL (lines 1 thru 33)		$ 4,032,657	$ 59,003		$ 140,097	$ 81,094	$ 2,606,519	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number St Agnes HC and Rehab Center # 0027870 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 4,032,657	$ 59,003		$ 140,097	$ 81,094	$ 2,606,519	1
2	Fire Pumps	2002	1,520		20	217	217	380	2
3	Water Heater Repairs	2002	1,830		20	153	153	254	3
4	Landscaping	2002	564		20	38	38	56	4
5	Ac Outlet Repairs	2002	880		20	88	88	132	5
6	Parking Lot Improvements	2002	850		20	57	57	76	6
7	Sink Line Repairs	2002	635		20	64	64	85	7
8	Wire Repairs	2002	750		20	75	75	94	8
9	Smoke Detectors	2003	514		20	73	73	73	9
10	Heating Motor	2003	975		20	68	68	68	10
11	Passenger Elevator	2003	3,260		20	109	109	109	11
12	Tiles	2003	991		20	66	66	66	12
13	Landscaping	2003	723		20	28	28	28	13
14	Smoke Detectors	2003	1,383		20	115	115	115	14
15	Pump Repairs	2003	510		20	26	26	26	15
16	Outlet Installation	2003	2,765		20	23	23	23	16
17	Gas Valve Replacement	2003	725		20	18	18	18	17
18	Metal Door	2003	543		20	45	45	45	18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,052,075	$ 59,003		$ 141,360	$ 82,357	$ 2,608,167	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number St Agnes HC and Rehab Center # 0027870 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 4,052,075	$ 59,003		$ 141,360	$ 82,357	$ 2,608,167	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,052,075	$ 59,003		$ 141,360	$ 82,357	$ 2,608,167	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number St Agnes HC and Rehab Center # 0027870 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 4,052,075	$ 59,003		$ 141,360	$ 82,357	$ 2,608,167	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,052,075	$ 59,003		$ 141,360	$ 82,357	$ 2,608,167	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number St Agnes HC and Rehab Center # 0027870 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 4,052,075	$ 59,003		$ 141,360	$ 82,357	$ 2,608,167	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,052,075	$ 59,003		$ 141,360	$ 82,357	$ 2,608,167	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number St Agnes HC and Rehab Center # 0027870 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 4,052,075	$ 59,003		$ 141,360	$ 82,357	$ 2,608,167	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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15									15
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,052,075	$ 59,003		$ 141,360	$ 82,357	$ 2,608,167	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number St Agnes HC and Rehab Center # 0027870 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 4,052,075	$ 59,003		$ 141,360	$ 82,357	$ 2,608,167	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,052,075	$ 59,003		$ 141,360	$ 82,357	$ 2,608,167	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number St Agnes HC and Rehab Center # 0027870 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		$ 4,052,075	$ 59,003		$ 141,360	$ 82,357	$ 2,608,167	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,052,075	$ 59,003		$ 141,360	$ 82,357	$ 2,608,167	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number St Agnes HC and Rehab Center # 0027870 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12J, Carried Forward		$ 4,052,075	$ 59,003		$ 141,360	$ 82,357	$ 2,608,167	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,052,075	$ 59,003		$ 141,360	$ 82,357	$ 2,608,167	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number St Agnes HC and Rehab Center # 0027870 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	197		1983	1983	$ 424,750	$	35	$	$	$ 424,750	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-BLDG, Line 70 for total

Facility Name & ID Number St Agnes HC and Rehab Center # 0027870 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 424,750	$		$	$	$ 424,750	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number St Agnes HC and Rehab Center # 0027870 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1988	1988	$ 55,577	$ 2,021	35	$ 1,588	$ (433)	$ 12,703	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Allocated from MADO Management			1993	21,169	564	20	1,058	494	11,034	9
10	Allocated from MADO Management			1995	1,289	257	20	65	(192)	548	10
11	Allocated from MADO Management			2000	3,166	-	20	158	158	558	11
12	Allocated from MADO Management			2001	1,371	22	20	69	(47)	187	12
13	Allocated from MADO Management			2002	2,157	-	20	195	195	337	13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

Facility Name & ID Number St Agnes HC and Rehab Center # 0027870 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 84,729	$ 2,864		$ 3,133	$ 175	$ 25,367	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number St Agnes HC and Rehab Center # 0027870 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 655,005	$ 21,854	$ 30,278	$ 8,424	10	$ 318,715	71
72	Current Year Purchases	19,891	5,497	816	(4,681)	10	816	72
73	Fully Depreciated Assets	3,100				10	3,100	73
74								74
75	TOTALS	$ 677,996	$ 27,351	$ 31,094	$ 3,743		$ 322,631	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		1995 JEEP LAREDO	1995	$ 25,368	$ 1,775	$	$ (1,775)	5	$ 18,321	76
77										77
78										78
79										79
80	TOTALS			$ 25,368	$ 1,775	$	$ (1,775)		$ 18,321	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,830,689	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 88,129	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 172,454	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 84,325	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,949,119	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [x] NO

16. Rental Amount for movable equipment: $ 8,981 Description: See Attached Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Agnes HC and Rehab Center # 0027870 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [x] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [x]
- HOURS PER AIDE

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [x]
- HOURS PER AIDE

B. EXPENSES

ALLOCATION OF COSTS (d)

			1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition		$	$ 1,600	$	$ 1,600
2	Books and Supplies					
3	Classroom Wages	(a)				
4	Clinical Wages	(b)				
5	In-House Trainer Wages	(c)				
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS		$	$ 1,600	$	$ 1,600
10	SUM OF line 9, col. 1 and 2	(e)	$ 1,600			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	4
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	4

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 10,152	$		$ 10,152	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			31,143			31,143	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			76,308			76,308	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				221,107		221,107	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	39 - 02					69,190		69,190	12
13	Other (specify): See Supplemental			176,228		37,795	287,554		501,577	13
14	TOTAL			$ 176,228		$ 155,398	$ 577,851		$ 909,477	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Agnes HC and Rehab Center **#** 0027870 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/03 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 67,616	$ 68,616	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,072,962	1,072,962	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	48,008	48,008	6
7	Other Prepaid Expenses	120	120	7
8	Accounts Receivable (owners or related parties)	3,792,715	7,190,106	8
9	Other(specify): See Attached Schedule	7,698	7,698	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,989,119	$ 8,387,510	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		75,250	13
14	Buildings, at Historical Cost		424,750	14
15	Leasehold Improvements, at Historical Cost	3,488,255	3,495,548	15
16	Equipment, at Historical Cost	195,210	1,174,727	16
17	Accumulated Depreciation (book methods)	(1,787,628)	(4,482,960)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		48,587	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(48,587)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):		1,288,774	22
23	Other(specify): See Attached Schedule		17,939	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,895,837	$ 1,994,028	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 6,884,956	$ 10,381,538	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 873,926	$ 873,927	26
27	Officer's Accounts Payable	5,237,762	6,313,535	27
28	Accounts Payable-Patient Deposits	29,084	29,084	28
29	Short-Term Notes Payable	35,000	2,910,339	29
30	Accrued Salaries Payable	91,648	91,648	30
31	Accrued Taxes Payable (excluding real estate taxes)	(10,893)	(10,893)	31
32	Accrued Real Estate Taxes(Sch.IX-B)	249,081	249,081	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	2,077	2,077	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 6,507,685	$ 10,458,798	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 6,507,685	$ 10,458,798	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 377,271	$ (77,260)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 6,884,956	$ 10,381,538	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number St Agnes HC and Rehab Center # 0027870 Report Period Beginning: 01/01/03 Ending: 12/31/03

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,004,699)	1
2	Restatements (describe):		2
3	**Expense Restatement**	189,101	3
4	**Income Restatement**	526,350	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (289,248)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	666,519	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 666,519	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 377,271	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Agnes HC and Rehab Center # 0027870 Report Period Beginning: 01/01/03 Ending: 12/31/03

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 8,185,808	1
2	Discounts and Allowances for all Levels	(428,635)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,757,173	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	550,063	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 550,063	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	330	12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	323,672	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	22,604	19
20	Radiology and X-Ray	6,850	20
21	Other Medical Services	570,950	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 924,406	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule		28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,231,642	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,039,654	31
32	Health Care	3,465,828	32
33	General Administration	1,431,867	33
	B. Capital Expense		
34	Ownership	600,035	34
	C. Ancillary Expense		
35	Special Cost Centers	919,882	35
36	Provider Participation Fee	107,857	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,565,123	40
41	**Income before Income Taxes (line 30 minus line 40)****	666,519	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 666,519	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number St Agnes HC and Rehab Center # 0027870 Report Period Beginning: 01/01/03 Ending: 12/31/03

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing			$	$	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,225	3,358	94,309	28.08	3
4	Licensed Practical Nurses	3,622	3,751	73,280	19.54	4
5	Nurse Aides & Orderlies	147,935	159,319	1,119,575	7.03	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	7,090	7,673	176,228	22.97	7
8	Rehab/Therapy Aides	1,602	1,715	17,601	10.26	8
9	Activity Director	6,356	6,611	46,871	7.09	9
10	Activity Assistants	11,226	12,443	79,330	6.38	10
11	Social Service Workers	9,942	11,026	102,227	9.27	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	4,623	4,961	34,618	6.98	17
18	Housekeepers	1,722	2,000	20,795	10.40	18
19	Laundry					19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,291	6,793	45,930	6.76	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental					33
34	TOTAL (lines 1 - 33)	203,634	219,650	$ 1,810,764 *	$ 8.24	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	377	$ 10,429	01-03	35
36	Medical Director	5	1,000	09-03	36
37	Medical Records Consultant	Monthly	4,128	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	41	1,817	10a-03	40
41	Occupational Therapy Consultant	Monthly	13,080	10a-03	41
42	Respiratory Therapy Consultant	133	4,419	10a-03	42
43	Speech Therapy Consultant				43
44	Activity Consultant	48	2,256	11-03	44
45	Social Service Consultant	73	3,988	12-03	45
46	Other(specify)				46
47	Dietary Outside Labor	47,059	392,850	01-03	47
48	Social Service Outside Labor	1,993	27,528	12-03	48
49	TOTAL (lines 35 - 48)	49,729	$ 461,495		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	57,161	$ 1,447,573	10-03	50
51	Licensed Practical Nurses	15,098	333,865	10-03	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	72,259	$ 1,781,438		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number St Agnes HC and Rehab Center # 0027870 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
			$
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$

B. Administrative - Other

Description	Amount
MADO Management - Management Fees	$ 660,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 660,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Renith Viloria	Consulting	$ 355
Personnel Planners	Unemployment Consulting	1,843
Wolf & Co.	Accounting	6,283
FR&R	Accounting	12,250
Adjusted Out Page 5	Appraisal Fee	2,500
HDSI	Data Processing	7,915
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 31,146

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 28,621
Unemployment Compensation Insurance	34,097
FICA Taxes	137,338
Employee Health Insurance	
Employee Meals	54,108
Illinois Municipal Retirement Fund (IMRF)*	
Employee Benefits	1,822
401K Employers Share	354
TOTAL (agree to Schedule V, line 22, col.8)	$ 256,340

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,000
Advertising: Employee Recruitment	24,843
Health Care Worker Background Check	3,735
(Indicate # of checks performed 335)	
Licenses and Dues	7,630
Allocated MADO Management	2,026
Advertising	2,593
Less: Public Relations Expense	( )
Non-allowable advertising	(2,593)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 39,234

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,774
Allocated MADO Management	152
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,926

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number St Agnes HC and Rehab Center # 0027870 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Agnes HC and Rehab Center **#** 0027870 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **77,567** Line **10-02**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **x** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **107,857**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **54,108** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100% In 14**
d. Have vehicle usage logs been maintained? **No**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **No**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ N/A

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.